You Asked for It! Advanced Strategies for DRGs, Inpatient Status Appeals, and Tackling Medicare Advantage Noncompliance with the 2-Midnight Rule

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Learning Outcomes

At the conclusion of the webinar, the learner will be able to determine factors that influence Diagnosis-Related Group (DRG) assignments and identify critical components of compliant appeals for denied inpatient status.

or

At the conclusion of the webinar, the learner will be able to self-report they can:

1. Pick out one factor that does not influence Diagnosis-Related Group (DRG) assignments.
2. Select one critical component required for a compliant appeal of denied inpatient status.
3. Identify one common scenario where Medicare Advantage plans deviate from the 2-Midnight Rule.

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Dr. Kendall Smith is a Senior Fellow in Hospital Medicine (SFHM) and currently acts as Chief Physician Advisor/Chief Medical Officer for PayerWatch - AppealMasters, a leading appeal educator and appeal services firm for hospitals and health systems. He's been deeply involved in denial and appeals management throughout his hospitalist career. He has served as a physician leader on hospital revenue cycle management teams while also serving as the Physician Advisor for Clinical Resource Management. Dr. Smith is also an AHIMA ICD-CM/PCS approved trainer/ambassador.

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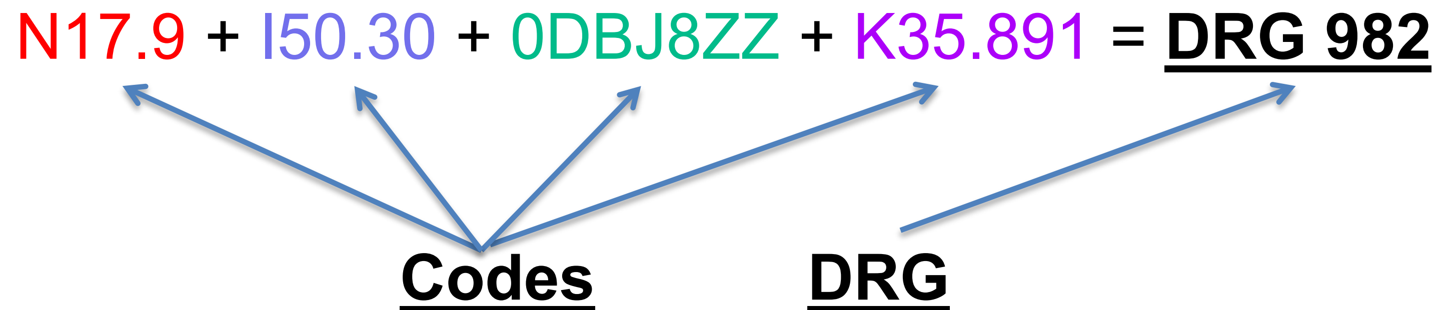
DRGs and Hospital Revenue – Beyond the Basics

Case Mix Index (CMI) – Quick Review

- **Case Mix Index (CMI):** measure used to reflect the clinical complexity of the patient population treated in a hospital
- **Calculation of CMI**: average of the relative weights of all the Diagnosis-Related Groups (DRGs) for patients treated during a specific period
- **Relative weights for DRGs**: assigned based on the resources required to treat patients within that group
- **Increased complexity of cases**→ increased use of resources → the higher the DRGs →the higher the CMI→ the higher the reimbursement → **direct influence on the financial health of the hospital**

Factors that Influence DRGs

- Documentation in the medical record
- Presence of **reimbursable** comorbid conditions/complications (CCs) and major comorbid conditions/complications (MCCs)
- Accurate coding
- Appropriate queries
  - CDI
  - Coding



Comorbid Conditions - Examples

Not reimbursable (not CCs or MCCs): CHF, anemia, respiratory distress, failure to thrive, fluid overload, edema, sodium, shocky, kidney failure, hypertension

Reimbursable

- **Comorbid conditions/complications (CCs)**: systolic congestive heart failure, acute blood loss anemia, malnutrition, hyponatremia, shock
- **Major comorbid conditions/complications (MCCs)**: acute systolic CHF, acute respiratory failure, severe malnutrition, hypovolemic shock
- Note – they change annually

CCs and MCCs

- The Impact on Severity of Accurate Coding

DRG	Description			Mort
482	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.57	4.3	0.15%
	"Shortness of Breath" No comorbidity documented			
481	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	1.93	5.3	0.70%
	Chronic Respiratory Failure (CC)			
480	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	3.04	8.5	7.81%
	Acute on Chronic Respiratory Failure (MCC)			

Payment per DRG

Numerous influences on DRG payment.

Base rate plus additional monies for:

- Complexity of cases
- Geographic location
- Teaching Status
- Disproportionate share adjustments

...And others

2024 Base rate average: $6,0497

- Base rate x DRG relative weight = conservative estimate of DRG payment.
  - ➢ $6,097 x DRG relative weight of 1.5 = $9,145.50

DRG Audit Downgrades

4 kinds

1. Coding: "**Coder, your coding was wrong**."

   Example: Acute respiratory failure is being resequenced as the principal diagnosis and COPD exacerbation is being resequenced as a secondary diagnosis.

   - Based on coding guidelines
   - Appeal with coding rationale/resources
   - Prove why the original coding was correct

2. Clinical validation (CV): "**Doctor, you misdiagnosed your patient**."

   Example: Acute respiratory failure is denied because the RR rate was 24, no ABGs were done, the lowest SpO2 was 95%, and no high flow oxygen was needed.

   - Based on clinical criteria.
   - Appeal with peer reviewed clinical criteria/clinical resources
   - Prove why the denied diagnosis was correctly diagnosed.

DRG Audit Downgrades

3. Dual: both coding and CV: **Coder, you coded a diagnosis incorrectly AND BTW doctor, you misdiagnosed your patient**.

Example: Acute respiratory failure is denied because the RR rate was 24, no ABGs were done, the lowest SpO2 was 95%, and no high flow oxygen was needed. Acute systolic CHF is denied because it was not documented in the discharge summary.

- Appeal with both coding and clinical resources
- Prove why the denied diagnosis was coded correctly **and** why the condition was diagnosed correctly

4. Payers use own proprietary information: Coders and clinicians unaware of proprietary "criteria."

Example: "Modified" SOFA criteria, Framingham criteria to diagnose CHF

- Monitor clinical validation denials
- Check contracts
- Consider evolving CDI to PDI

Appeal Strategies

First and foremost:

Never, EVER believe that the payer's rationale is correct.

- ***Scrutinize EVERY reason given to deny.***
- ***Push back at EVERY reason given that is not correct.***

Do more than just state the facts…

Justify your appeal with direct rebuttals

Scenario: Sepsis denied as it did not meet SOFA criteria. SOFA criteria and sepsis 2 were both met. An excerpt from the appeal…

It should be noted that the auditor erred in dismissing the patient's shortness of breath and low oxygen saturation levels on admission resulting in low P/F ratios. No other respiratory conditions were present to account for this acute change from baseline.

Likewise, the auditor failed to account for the patient's hypotension and low MAP values.

Furthermore, the auditor erred in claiming that platelet values are only determined after hydration. There is no consideration given to hydration status in SOFA scoring – only in assessing the patient's baseline status and calculating score in consideration of such.

The patient's total SOFA score was 5. Thus, the patient met EVERY consensus-based criteria for sepsis, thereby validating the diagnosis in question.

Clinical Criteria and Code Assignment

Coding Clinic, Fourth Quarter 2016, Page 147
Effective with discharges October 1, 2016

"…A facility or a payer may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis, but that is a clinical issue outside the coding system…"

Implications:

1. **Provider Documentation is Paramount:**
   Diagnosis codes are assigned based on the physician's documentation, regardless of clinical definitions or criteria.
2. **Coding vs. Clinical Judgment:**
   Clinical definitions or criteria used by facilities or payers do not dictate coding decisions.
   Coders must focus on the documented diagnosis, not the clinical validation of the condition.
3. **Facility and Payer Influence:**
   Facilities and payers may enforce their own clinical definitions for operational purposes, but this does not alter coding guidelines.

Why This Matters:

- Protects the integrity of the **coding process** by ensuring it remains tied to provider documentation.
- Highlights the separation between clinical judgment, operational requirements, and coding rules.
- Helps resolve disputes over coding versus payer clinical validation audits.
- **Bottom Line:**
  Coders must adhere to the documented diagnosis, as clinical definitions or criteria are beyond the scope of the coding system.

Scrutinize sources used to deny

Scenario: Acute respiratory failure is denied based on clinical information from Coding Clinics

When a payer uses clinical information from Coding Clinics, push back hard.

Clinical criteria found in Coding Clinics are NOT acceptable to deny on a clinical basis.

- It is also not acceptable to use them to appeal on a clinical basis.

Appeal Strategies: Clinical Source Documents

Use Coding Clinics to prove they should not be used to deny on a clinical basis.

Source/Reference	**Applying Past Issues of AHA Coding Clinic for ICD-9-CM to ICD-10** ***Coding Clinic*, Fourth Quarter 2015: Page 20**
Practice Guideline Recommendation	…*Coding Clinic* may still be useful to understand clinical clues when applying the guideline regarding not coding separately signs or symptoms that are integral to a condition. **Users may continue to use that information, as clues—not clinical criteria.**

Appeal Strategies: Clinical Source Documents

Source/Reference	**Use of *Coding Clinic* as Clinical Criteria for Code Assignment** ***Coding Clinic*, Third Quarter 2008 Page: 16**
Practice Guideline Recommendation	**Question:** Can background clinical information published in Coding Clinic be used as clinical criteria for code assignment? **Answer:** **No, background material published in *Coding Clinic* cannot be used as clinical criteria for code assignment**. As stated in *Coding Clinic,* Second Quarter 1998, pages 4-5: "**Any clinical information published in *Coding Clinic*, is provided as background material to aid the coder's understanding of disease processes**. The information is intended to provide the coder with 'clues' to identify possible gaps in documentation where additional physician query may be necessary…

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A Word (or three) About Queries

CDI professionals and coders must follow *ACDIS and AHIMA's Guidelines for Achieving a Compliant Query Practice*.

"When to Query

Queries may be necessary in (but not limited to) the following instances:

a. To support documentation of medical diagnoses or conditions that are clinically evident and meet the Uniform Hospital Discharge Data Set (UHDDS) requirements but without the corresponding diagnoses or conditions stated…

…**d. To seek clarification when it appears a documented diagnosis is not clinically supported or conflicting with the medical record documentation (clinical validation)**."

A Word (or three) About Queries, continued

Queries can be a powerful tool to prevent CV denials.

Don’t forget – it is appropriate to query **when it appears a documented diagnosis is not clinically supported.**

Tips to gain physician buy-in:

- Engage your physician advisor to help if needed.
- Explain to the physician WHY the query was posed.
- Show the physician actual denials (PHI removed).
- If you have denials involving the physician's patient(s), show them to that physician.
- Don’t be afraid to link denials to decreased CMI, the hospital “report card”, individual physician statistics.
  - Targeted education
- Speak with department heads.
- Get on the agenda for department meetings.

CCs and MCCs

DRG **without** CC or MCC = ↓relative weight, ↓GMLOS, **$**

- DRG 684 Renal failure without CC/MCC = RW 0.6085, GMLOS 2.2

DRG **with CC** = ↑relative weight, ↑GMLOS, **$$**

- DRG 683 Renal Failure with CC = RW 0.9008, GMLOS 3.1
  - ✓ Likely to be targeted for denial

DRG **with MCC** = ↑↑relative weight, **$$$**

- DRG 682 Renal Failure with MCC = RW 1.5008, GMLOS 4.4
  - ✓ Very likely to be targeted for denial

Enforcement Strategies

Case Study – Medicare Advantage

Appeal or no appeal?

Scenario:

Elderly lady with flank pain, nausea, vomiting, cough. Unable to keep down much except popsicles. Found to have pyelonephritis and possible pneumonia. Baseline creatinine around 1.2. Creatinine level in ED 1.5. Started on IV fluids and IV cefepime in the ED. Diet: clear liquids as tolerated. Well documented expectation for a 2-midnight hospitalization. IV fluids and IV antibiotics were ordered.

Inpatient status denied because there was no documentation of need for continuing treatment with IV antibiotics and/or IV fluids.

Case Study – Medicare Advantage

Appeal! It's all about the expectation.

The **expectation** of a 2-midnight stay was reasonable. She was nauseated with vomiting, had an infection, and couldn't keep anything down except popsicles. Her kidneys were already negatively impacted. She needed both IV fluids and IV antibiotics.

It does not really matter what happened AFTER the order was written, though that information can help support that the admission was appropriate.

Don't forget to address any errors made by the payer.

The UHC denial letter states "no documentation of need for continued IV antibiotics." However, Ms. Doe remained nauseated with occasional vomiting until (date). She was continued on IV antibiotics until (date). Her diet was not advanced until (date). She was treated in good faith and required greater than a two midnight stay for recovery and medical optimization. Traditional Medicare would have covered this admission, therefore, UHC must as well.

“Selective Interpretation” by MA Payers

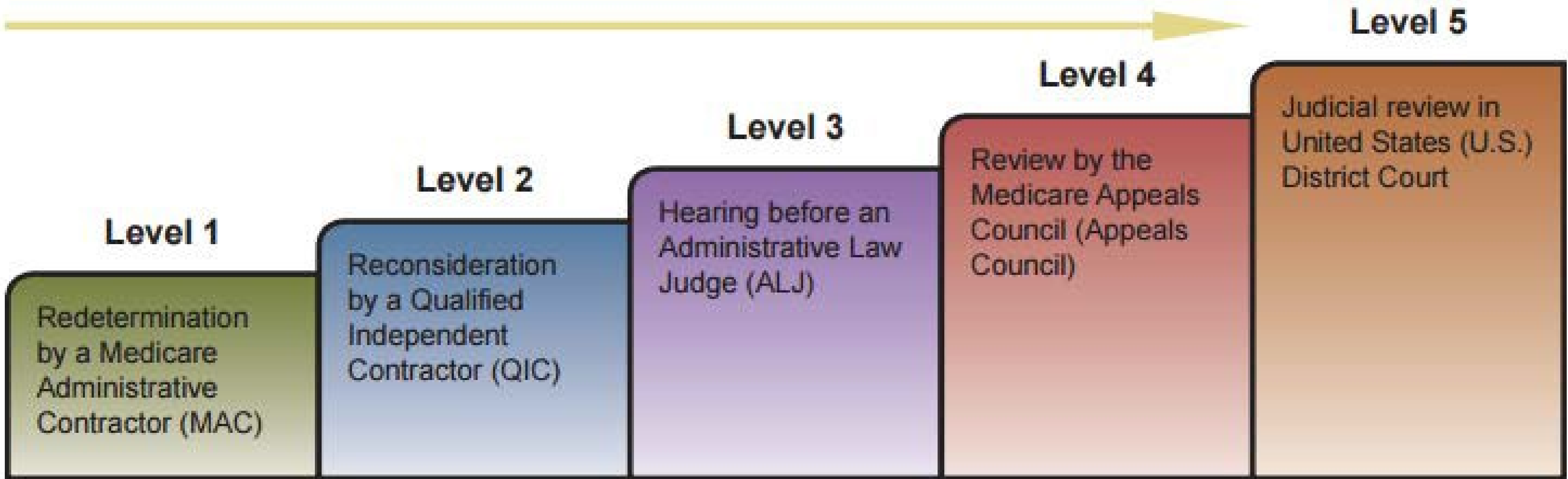
Frequent denial rationale:

- Must fail a period of observation. FALSE
- Must meet InterQual criteria. FALSE
- Must meet MCG criteria. FALSE
- Must exhibit any number of specific signs and symptoms or conditions. FALSE

- HOWEVER: **CHECK YOUR CONTRACTS!!**

A Quick Guide to the ALJ and External Review Processes

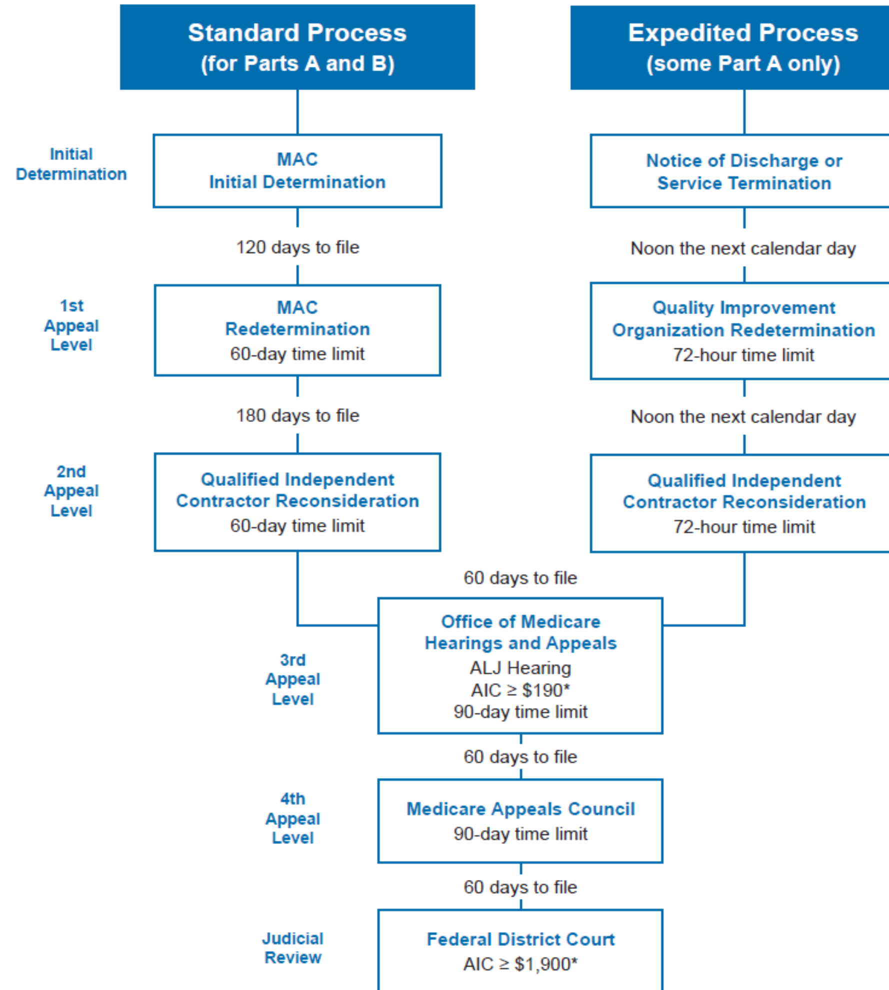
The Administrative Law Judge (ALJ) Process – Traditional Medicare



From the HHS PRIMER: The Medicare Appeals Process

https://www.hhs.gov/sites/default/files/omha/files/medicare-appeals-backlog.pdf

The ALJ Process



AIC: Amount in Controversy

ALJ: Administrative Law Judge

MAC: Medicare Administrative Contractor

*The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index.

The chart reflects the amounts for calendar year 2025.

https://www.cms.gov/medicare/appeals-and-grievances/orgmedffsappeals/downloads/flowchart-ffs-appeals-process.pdf

EXTERNAL REVIEW (Commercial, non-Medicare Advantage)

- Must usually exhaust internal levels of appeal.
- Different states might have different rules.

Hospital **contracted** with the payer:

- Pre-negotiated agreements about appeal processes
- More streamlined and defined process for the appeal process
- Binding decisions

Hospital **NOT Contracted** with the Payer*

- No pre-negotiated agreement → less predictable appeal processes
- Different states → different rules
- Less leverage → more chance of being upheld

*Patient appeal rights >>> than hospital appeal rights

*Consider patient AOR (appointment of representative) to appeal on behalf of the patient

The 2-Midnight Rule – Expert Application and Exceptions

Inpatient Status Exceptions – Defining the Nuances

- **Exceptions to the 2-Midnight Rule**:
- **CMS Inpatient-Only List**: Each year, CMS publishes an "Inpatient-Only" (IPO) list that identifies procedures requiring inpatient status because of their complexity, risk, or necessity for post-procedure monitoring. Examples include **TAVR**, **emergency CABG**, and other high-risk surgeries.
- **Highlighting Critical Updates**: The IPO list is reviewed and updated annually, so it's essential for hospitals to stay current with changes. For example, a previously outpatient-eligible procedure may be added to the IPO list due to evolving standards or patient outcomes.
- **Documentation for Compliance**:
  - Clearly state in the medical record that the procedure is on the CMS IPO list.
  - Provide pre-operative and post-operative details demonstrating the necessity of inpatient care.

Common Documentation Pitfalls

Issues:

- Incomplete or vague physician notes.
- Failure to document the expected length of stay.
- Lack of specificity regarding the patient's condition and treatment plan.

Solutions:

- Implement regular training sessions for physicians and CDI teams.
- Use standardized templates to ensure comprehensive documentation.
- Conduct periodic audits to identify and correct documentation deficiencies.

Documentation Gaps – A Common Denial Trigger

- **Key Weaknesses**:
  - Lack of detailed *physician intent* (e.g., "admit to inpatient for monitoring" without rationale).
  - Absence of updates on progression for cases like sepsis or unstable angina.
  - Failure to include "why outpatient care isn't sufficient."
- **Specific Example**:
  - **Weak Note**: "Admitted for chest pain."
  - **Strong Note**: "Patient with unstable angina, high risk for arrhythmia, requiring telemetry monitoring and IV therapy not feasible in outpatient."
- **Tip**: Train physicians to document not just the *what* but the *why*.

Appealing Medicare Advantage Noncompliance

Noncompliance Scenarios:

- Denials for inpatient stays despite meeting the **Two-Midnight Rule** expectation.
- Non-recognition of **inpatient-only procedures** as appropriate admissions.

Steps to Appeal:

Cite Authoritative Guidance:

Refer to the **Medicare Benefit Policy Manual, Chapter 1, §10**:

Emphasizes the Two-Midnight Rule and physician judgment in admission decisions.

Highlights the need for proper documentation to support inpatient status.

Highlight CMS Guidance:

Use the official CMS Fact Sheet on the **Two-Midnight Rule** (cms.gov):

Reinforces the requirement for MA plans to align with Medicare's inpatient admission criteria.

Document and Justify:

Provide clear, detailed documentation supporting the physician’s decision.

Address how the denial violates CMS policies.

Provider Complaint Process for Medicare Advantage Plans

- The **Provider Complaint Process** allows healthcare providers to submit complaints about **Medicare Advantage (MA) plans** directly to the Centers for Medicare & Medicaid Services (CMS).
- Complaints typically address issues such as:
  - **Claim denials**
  - **Unjustified delays in payment**
  - **Inappropriate application of coverage rules**
  - **Network adequacy concerns** (e.g., access to specialists).

Why It's Critical:

Accountability for MA Plans:

Helps CMS monitor and enforce compliance with federal regulations by Medicare Advantage organizations.

Improved Payment Practices:

Identifies patterns of **unfair practices** such as delays or inappropriate denials, ensuring providers are reimbursed fairly and on time.

Ensuring Patient Care:

Holds MA plans accountable for coverage decisions that could impact **patient access** to medically necessary services.

Data-Driven Policy Improvements:

Provider complaints supply CMS with actionable data to refine **oversight policies** and prevent systemic issues.

Take Action:

- **How to File**:
  - Use the **CMS Provider Complaint Submission Module** through the CMS Complaints Portal.
  - Include **specific details** about the issue: plan name, beneficiary details (if relevant), dates, and nature of the complaint.
- **Outcome**:
  - CMS investigates complaints and may impose corrective actions or penalties on non-compliant MA plans.

Recent CMS Updates Influencing the Interpretation of the Two-Midnight Rule

Inclusion of Medicare Advantage Plans under the Two-Midnight Rule

- **Policy Extension**: As of January 1, 2024, the Centers for Medicare & Medicaid Services (CMS) mandated that Medicare Advantage (MA) plans adhere to the Two-Midnight Rule. This policy requires that inpatient admissions are generally appropriate for Medicare Part A payment if the admitting physician expects the patient to require hospital care spanning at least two midnights.

Clarification on Inpatient Admission Criteria

- **Guidance Issuance**: In February 2024, CMS released a Frequently Asked Questions (FAQ) document providing guidance on how the Two-Midnight Rule applies to MA patients. The document clarifies that while MA plans are not required to follow the "two-midnight presumption," they must adhere to the inpatient admission criteria outlined in 42 C.F.R. § 412.3, which includes the Two-Midnight benchmark.

Recent CMS Updates Influencing the Interpretation of the Two-Midnight Rule

Strengthening Program Safeguards

- **OIG Recommendations**: In June 2024, the Office of Inspector General (OIG) identified weaknesses in CMS's safeguards for preventing and detecting improper payments for short inpatient stays. The OIG recommended that CMS implement prepayment edits and enhance policies for post-payment reviews to ensure compliance with the Two-Midnight Rule. Office of Inspector General

Emphasis on Physician Judgment and Documentation

- **Policy Flexibility**: CMS continues to emphasize the importance of physician judgment in admission decisions. While the Two-Midnight Rule provides a general framework, CMS acknowledges exceptions based on clinical judgment, particularly in cases where an inpatient stay of less than two midnights is deemed necessary. Thorough documentation supporting the physician's decision remains crucial for compliance and reimbursement.

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Questions and Answers

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